VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 25, 2012

Mr. Thomas Rice, Administrator
Brookside Health And Rehabilitation
1200 Christian Street
White River Junction, VT 05001-9267

Provider #475010

Dear Mr. Rice:

Enclosed is a copy of your acceptable plans of correction for the re-certification survey conducted on **August 29, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475010	A. BUILDING _____ B. WING _____	08/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HEALTH AND REHABILITATION	1200 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey was conducted by the Division of Licensing and Protection from 08/27/12 through 08/29/12. The following deficiencies were identified.	F 000	**Disclaimer** The filling of this plan of correction is filed as the facility's does not constitute the fact that deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply the requirements and provide High quality care	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to use the results of assessments to develop a comprehensive plan of care for two residents. This affected two (Resident #94 and Resident #14) of twenty-three Stage II sample residents. Findings include:	F 279	F279 1. Resident #94 has been assessed, no negative outcome as a result of this alleged deficient practice. Care plan has been implemented that addresses urinary incontinence. Resident #14 has been discharged from the facility. 2. Residents with urinary incontinence may be affected by this alleged deficient practice. 3. Resident whom are incontinent of urine evaluated and plan implemented by 9/26/12 SEE NEXT PAGE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas E. Price — TITLE: Administrator — (X6) DATE: 9/30/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1	F 279		

1. Per record review and staff interview, no care plan for Urinary Incontinence was found for Resident #94 who has urinary incontinence. There is a Bladder and Bowel Retraining Sheet in the record for the month of May. On admission Resident #94 is noted to be continent during the day with one person assist and wears a pull-up at night. Review of the Licensed Nurse Aid (LNA) charting in the period previous to the admission Minimum Data Set assessment (MDS), notes there are numerous evening and night shift spaces to indicate incontinence which are left blank. In June and July when the charting is more more complete, it becomes evident Resident #94 is incontinent on evening and night shifts much more regularly than during the day.

The LNA flow sheets for the month of August reflect frequent episodes of incontinence with an increase of episodes during the day shift. Resident #94 was on Hospice when admitted and was care planned in the Hospice Care Plan, for incontinence. This Care Plan was discontinued when Hospice discharged Resident #94 on 7/10/12. The LNA flow sheet indicates Resident #94 requires limited assistance of one person for toileting. There is no information in the Activities of Daily Living (ADL) section regarding the need for cueing for toileting, toileting frequency or night time incontinence checks. There is no current Incontinence Care Plan in the record. There is an LNA care plan in the LNA assignment book which states, under toileting, that Resident #94 requires extensive assistance of one person and is incontinent of bladder.

In an interview on 8/26 at 4:40 P.M. an LNA

3. Resident whom are incontinent of urine and residents who have foley catheters evaluated and plan implemented by 9/26/12
4. Nursing staff re-educated for process of care planning for residents who have urinary incontinence and foley catheters by 9/26/12
5. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance and further surveillance.
6. Plan completed by 9/26/12. Director of Nursing or designee responsible for implementation

F279 POC accepted 9/24/12
TMynhierRN1 RNC

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F 279	Continued From page 2 stated that Resident #94 is to be toileted Q2H (every two hours) on evenings and can usually ask to be toileted reliably. S/he further stated that there was a period of time when Resident #94 was having more urinary incontinence but now s/he is not as often incontinent of urine except on nights when s/he is asleep. In an interview on 8/29/12 at 9:50 A.M., the Unit Manager confirmed that there should be a care plan for Urinary Incontinence in the chart and that it was not present. 2. Review of the closed record for Resident #14 included an Admission assessment dated 04/17/12 indicating that Resident #14 was admitted from the hospital with a Foley catheter in place. The Resident was discharged to the hospital on 06/27/12. No plan of care was located for the use of a Foley catheter. Interview of the Registered Nurse (RN) Unit Manager on 8/29/12 at 1:30 P.M. confirmed that Resident #14 was admitted on 04/17/12 with a Foley catheter in place. The RN was not able to locate a plan of care for the use of the Foley catheter.	F 279		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 1. Tiles in the B wing shower room repaired or replaced. All residents using this room have been evaluated and no injuries have occurred as result.	

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the resident environment remained as free from accident hazards as possible. Findings include: Per observation on 8/27/12 at 10:08 A.M., there were seven approximately one inch tiles in the "B" wing shower room that were loose. Several tiles were displaced from their original position and were located on top of existing tiles, creating a potential hazard. During interview on 8/27/12 at 10:15 A.M., a Unit Nurse confirmed that the shower was currently used by residents and that the loose tiles created a slipping hazard. The Unit Nurse also stated "that could cut someone's foot".	F 323	2. Residents who use the shower/tub room may be affected by this alleged broken or misplaced tiles. 3. Tiles throughout building to be checked. If defective or misplaced they will be repaired by 9/26/12. 4. Process implemented to regularly check for broken or defective tiles. By 9/26/12 5. Maintenance and housekeeping staff educated for implementation of this process. By 9/26/12. 6. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance and further surveillance. 7. Plan completed by 9/26/12. Administrator or designee responsible for implementation	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		

F323 POC accepted 9/24/12
TMynhierRN/PMC

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F 431	Continued From page 4 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews. the facility failed to assure that two medications requiring refrigeration at 36-46 degrees F (2-8 C) were stored at appropriate temperatures for seven consecutive days (8/19-25/12). Findings include: 1. During inspection of the facility's central drug storage unit on 8/28/12 at 1:00 P.M., the August temperature log for the central drug storage refrigerator was found to have recorded daily readings as follows (in degrees F): 8/19/12 - 33; 8/20/12 - 34; 8/21/12 - 33; 8/22/12 - 34; 8/23/12 - 33; 8/24/12 - 34; 8/25/12 - 34. Each of these recordings on the temperature log was signed by a nurse. During this initial inspection at 1:00 P.M., the Director of Nurses (DNS) confirmed that the temperature log contained the seven consecutive temperatures as listed above, and	F 431	F431 1. Affected medication immediately removed from service, 2. Residents receiving immunizations from medication out of this refrigerator during this time frame checked. No negative outcome sustained as a result of this alleged deficient practice. 3. All residents who receive medication from refrigerator have the potential to be affected by this alleged deficient practice. 4. Process for refrigerator check updated to reflect acceptable temperature parameters and actions to be taken if refrigerator falls out of these parameters. By 9/26/12 5. Nursing staff educated for process upgrades by9/26/12.	

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F 431	Continued From page 5 that the log did not specify a safe temperature range or instructions to staff regarding actions required when the refrigerator temperature went out of safe storage range. Upon inspection of the refrigerator's contents, there was a sealed plastic bag containing 22 single dose vials of Pneumovax (a vaccine used to help prevent pneumonia). The pharmacy label on the plastic bag indicated that delivery of the vaccine had occurred on 8/15/12. The Pneumovax box instructions included the manufacturer's recommendation to store the vaccine at 36-46 degrees Fahrenheit (F) or 2-8 degrees Celsius (C). Additionally, a sealed plastic bag contained 4 boxes of 10 doses (40 total doses) of Tuberculin purified protein derivative (PPD, which is used for tuberculin skin testing). The pharmacy label on the plastic bag indicated that the PPD had been delivered on 8/15/12, and the manufacturer's box label instructions recommended storage of the PPD at 36-46 F. At 1:15 P.M., the facility's consulting pharmacist confirmed that the Pneumovax and PPD showed pharmacy delivery on 8/15/12 and bore manufacturer's instructions for storage between 36-46 F (2-8 C). At 1:20 P.M., the Assistant Director of Nursing (ADNS) stated that the expectation of the nurses who check the refrigerator temperature is to report out of range temperatures to the maintenance department, either verbally or through the maintenance communication log. On 8/29/12 at 12:10 PM, the Director of Maintenance confirmed that s/he had not been notified, verbally or in writing, of the refrigerator temperature concern until after the inspection on the afternoon of 8/28/12. The	F 431	6. Random weekly audits x4 to ensure continued compliance. Results to be reported to QAA x3 for determination of compliance and further surveillance. 7. Plan completed by 9/26/12. Director of Nursing or designee responsible for implementation F431 POC accepted 9/24/12 TMynhierd | PMC	

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F 431	Continued From page 6 facility's written drug storage policy states, "Medications requiring 'refrigeration' or 'temperatures between 2 C (36 F) and 8 C (46 F)' are kept in a refrigerator with a thermometer to allow temperature monitoring". The policy does not contain written instruction to staff regarding what they should do in the event that temperatures are found to be out of the recommended range. At 2:00 P.M. on 8/28/12, the pharmacist informed me that the manufacturer's recommendation was to discard the PPD, and that the Pneumovax "was a close call", but had not been compromised.	F 431		